State Child Fatality Review Report
SFY 05-06
G.S. 143B-150.20

Family Support and Child Welfare Services Section
Division of Social Services
NC Department of Health and Human Services

2006

Report to the General Assembly
From the State Fatality Review Team

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State Child Fatality Review Report - SFY 05-06
Executive Summary

The Department of Health and Human Services, Division of Social Services (the Division), has the responsibility to convene a State Child Fatality Review Team to "conduct in-depth reviews of the child fatality which occurred involving children and families involved with local Departments of Social Services (DSS) child protective services in the 12 months preceding the fatality." The purpose of these reviews is to "implement a team approach to identifying factors which may have contributed to conditions leading into the fatality and to develop recommendations for improving coordination between local and State entities which might have avoided the threat of injury or fatality and to identify appropriate remedies." These reviews are mandated by statute (G.S. 143B-150.20) with specified team membership that includes representatives from the Division of Social Services, the county DSS, representatives from the local Community Child Protection Team (CCPT), the local Child Fatality Prevention Team (CFPT), local law enforcement, a medical expert, and a prevention specialist.

The reviews consist of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children. A formal report is issued at the conclusion of each review that includes the findings and recommendations from the State Child Fatality Review Team. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team (CCPT). The written report is available to anyone who requests it. Following the issuance of each report, Division of Social Services staff present the recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each state level recommendation.

Reviews and final reports are not necessarily completed during the SFY in which they occur. During SFY 05-06, 50 final reports were issued following completion of the reviews. These reviews were for child fatalities reported in SFY05-06 as well as in the prior year. There were a total of 189 child deaths reported during SFY 05-06. From these, the Division identified 40 child fatalities that met the criteria for a State Child Fatality Review Team review. Because of the overlap from SFY to SFY, some of the 40 fatalities identified during SFY05-06 were actually the subject of the final reports issued the same year. Out of the 40 deaths, neglect was suspected to have contributed to the fatality in 17 cases, abuse was suspected in 12 cases and in11 cases the cause of death was undetermined at the time the fatality intake was reported to the Division. Of the 17 neglect related deaths, 3 resulted in criminal charges and of the 12 abuse cases, 11 resulted in criminal charges.

For the reviews conducted during the year, the review teams identified six major themes. First, the review teams identified the need for the local DSS to improve in the area of compliance with policy and best practice. In an effort to assist local DSS agencies with improvement, there were a variety of recommendations made for the Division and local DSS agencies. Secondly, legal issues were prevalent during this period for reviews. This particular theme involved judges, law enforcement and attorneys. There were areas where legal issues were not being thoroughly addressed and/or timeliness was a concern. The third major theme involved the need for statewide case management system for child welfare. This system would allow documentation to be accessible across county lines and would enhance services to families. The fourth major theme is in the area of Mental Heath Services for families. At times, these services are unavailable, in addition to not being tailored to meet the needs of each individual. The fifth major theme is in the medical area, to include the need for improved collaboration between medical professionals and DSS staff; the need for establishing protocols and procedures amongst these two entities; and the need for medical services designed to support children

with special needs. Finally, non-compliance with the reporting law is another major theme. Additional themes and issues were identified and are listed in Appendix A to this report. Appendix B lists accomplishments by local communities as a result of recommendations from reviews.

State Child Fatality Review Team
Annual Report

Pursuant to G.S. 143B-150.20, the following is the State Child Fatality Review Team annual report to the N.C. General Assembly for SFY 05-06. This report includes a summary of findings and recommendations of child fatality reviews conducted by the State Child Fatality Review Teams during SFY 05-06. These teams conduct multidisciplinary reviews when there is suspicion that neglect or abuse caused a child's death and the county DSS children's services program was involved with the child or family any time in the previous year.

I. History

In 1997, the General Assembly enacted G.S. 143B-150.20 and established the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local DSS child protective services in the 12 months preceding the fatality.

The collaborative, multi-disciplinary approach to these reviews, along with information available to the public through the review reports, make these reviews learning tools for the entire community. These reviews can teach us how we can improve our efforts to prevent future child deaths.

Feedback from those involved with State Child Fatality Review Teams has been that there is ownership by the local communities with Review Team recommendations and commitment to implementation of the resulting action plans. The State Child Fatality Reviewers have implemented six-month follow-up contacts with the local CCPT's after a review is completed. These follow-up contacts with the CCPT's focus on the progress at the local level in implementing any systemic changes as a result of the recommendations from the Review Team.

II. Review Process

Currently, child fatality reviews are conducted as follows:

A. By State law, anyone who has cause to suspect that a child has died as the result of maltreatment must report the case to the director of the county DSS.

B. The county DSS reports to the Division information that they receive regarding any child who is suspected to have died as a result of maltreatment.

C. The Division determines whether the necessary criteria are met to invoke a review by a State Child Fatality Review Team based on information from the county DSS and any local law enforcement or health care professional who was involved in investigating the child's death or the death scene.

D. A State Fatality Review Team is convened, including representatives of the Division, the county DSS, and representatives from the local CCPT, the local CFPT, local law enforcement, a medical expert, and a prevention specialist.

E. Division staff on the team begins all reviews with an introduction about the review process to all participants.

F. The review consists of interviews with selected individuals and reviews of case records of the county DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children.

G. The team writes a report that includes the findings of the review and recommendations for system improvement.

H. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to anyone who requests it.

I. As each State Child Fatality Review Report is completed and released, the Division staff present recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each recommendation. Recommendations that need to be addressed by the Division are referred by the Fatality Reviewer to the Division Management Team for a ruling on any necessary action.

III. Facts regarding State Child Fatality Review Process

The State Child Fatality Review process is an ongoing one, and there is overlap from one fiscal year to the next. Therefore, reviews conducted and reports issued include fatalities that were reported to the Division and decisions to conduct reviews from the previous fiscal year as well as those from the current fiscal year. Some of the cases identified for review in the current fiscal year will be reviewed in the next fiscal year. During SFY 05-06, 50 final fatality review reports were issued following the completion of reviews.

The Division identified 40 child fatalities (out of 189 deaths reported) in 26 counties that met the criteria for a State Child Fatality Review Team review during SFY 05-06. Eight of the 40 child fatalities accepted for intensive child fatality reviews included the death of two children in the same household. To meet the criteria for a State Child Fatality Review, there had to be a suspicion that abuse or neglect was a factor in the fatality. In addition, the child or family must have been involved with a local DSS child protective services unit in the 12 months preceding the fatality. Of these 40 child deaths, neglect was suspected in 17 cases, abuse was suspected in 12 cases and 11 were reported at intake to be undetermined. Two fatality intakes from SFY 05-06 were pending a decision at the time the Annual Report was compiled.

IV. Fatality Reviews/Major Themes SFY 05-06

The State Child Fatality Review Teams often identify similar issues in the cases that they review. However, there are times when these teams identify major issues that had not been noted previously but that have statewide impact. Generally, these additional findings are more case specific or community specific.

The six most commonly identified major findings and lessons learned from the 50 child fatality reviews completed during SFY 05-06 are summarized here so that the State Division of Social Services, county Departments of Social Services, and other state and county agencies can make systemic improvements focused on the safety of children. Achievements at the state level related to these findings are noted where relevant at the time the individual fatality reports were issued. Appendix A reflects recommendations that were identified less often or that were more case-specific but that were still important recommendations that should be considered statewide. Appendix B reflects achievements at the local level that have resulted from recommendations from State Child Fatality Reviews.

A. Inconsistent Compliance with Policy and Best Practice Issues

Best practice and compliance with policy was a central theme in the annual report for SFY04-05. This continues to be a major area identified in twenty counties that participated in a state fatality intensive review during this past fiscal year. In many of the fatalities reviewed, the review teams identified the need for thorough child protective services investigations and assessments. In a number of the reviews, the allegations were not thoroughly assessed nor was sufficient contact with the family, children or persons who had knowledge about the family maintained to assess the level of risk in families. These steps are an integral part of a thorough assessment and can lead to tragic outcomes if not completed. A thorough assessment begins at the intake process and does not end until the risk to the children is sufficiently reduced and the case is closed by the local DSS.

The Children's Service Manual, Chapter 8, Section 1407 "Structured Intake" and Section 1408 "Receiving and assessing reports of abuse, neglect or dependency" guides decision making and practices regarding assessing child protective services intake reports and a thorough assessment of all factors present within a family. Using a holistic approach in identifying family's strengths and needs is crucial to providing a thorough assessment of any and all risk factors and safety. Several reviews noted that ongoing social work practice is incident focused which limits the agencies ability to see all the risk factors to accurately assess child safety.

Collaboration among DSS's, cross county and across state lines continues to be a barrier. Several reviews indicated that communication between internal departments of DSS should enhance services to families. This communication includes child and family team meetings to collaborate and communicate with family members and service providers, discussions with licensing workers prior to placement of children in foster homes and then ongoing monthly communication to address additional needs, and joint home visits when cases have been transferred across county lines. DSS continues to struggle with ensuring children are safe and services are provided when families move across county and state lines.

The Division's Staff Development and Training Team and Children's Program Representatives continue to provide local DSS with training and technical support as North Carolina implements system reform in Children Services. As we move forward, to include full implementation of Multiple Response System (MRS) in all 100 counties, several fatality reviews pointed out inconsistencies with case decisions. Also, some local DSS staff struggled with the MRS Family Assessment at the point of making the case decision. This learning curve was expected. The Division will continue to tailor training and technical support to meet the needs of each community.

Finally, once again it is important to note that staff turnover and high caseloads were found to be contributing factors in many situations that involve DSS agencies' lack of compliance with policy and shortcomings with best practice. Also, during SFY 05-06 the North Carolina Association of County Directors of Social Services (NCACDSS) collaborated with the Division and held a Staff Turnover and Retention Summit. Recommendations from this summit are being implemented.

B. Legal/Criminal Issues

Law Enforcement agencies provided a vital role in the protection of children and hence, there should be a joint collaboration between the Department of Social Services and law enforcement agencies. Of the fifty reports issued, nineteen cases had recommendations surrounding or involving law enforcements agencies in sixteen counties. Several reviews indicated a need to strengthen the laws surrounding child deaths related to abuse or neglect, to charge parents when crimes are committed and children are involved and to actively pursue felony murder charges when parents or caretakers murder their children. In addition, several reviews pointed to a lack of charges and convictions related to child deaths.

Unfortunately law enforcement agencies are not always notified when a child dies of unnatural or unexpected causes. When no notification is given, it prevents a thorough investigation which includes securing the crime scene and interviewing all parties that have knowledge of the death. In addition, law enforcement agencies don't always notify the local DSS of these fatalities that may leave surviving children vulnerable if the death is under suspicion.

The Office of the Chief Medical Examiner implemented a pilot protocol, "North Carolina Child Death Investigation Protocol" to be implemented in selective counties across the state. This provides a standardized method for conducting child death investigations. The focus is on investigations being interdisciplinary and collaborative in order for essential information to be gathered, shared and analyzed. Several counties volunteered over the past fiscal year to participate in this pilot.

Additionally recommendations that were noted in reviews include the criminal court judges being aware of DSS involvement when issuing court orders, ongoing funding for family court, local district attorney's aggressively pursuing drug related charges and domestic violence charges and thorough investigations by law enforcement agencies.

C. NCFAST

A new theme for this past fiscal year was the inability for counties to have quick access to child welfare documentation from other counties. Families are becoming increasingly transient and move from county to county. Unfortunately when they are involved in the child welfare system, the receiving county must call and request a hard copy of the record from the home county. This delay in obtaining the record can potentially jeopardize child safety. In addition, this impacts after hour social workers because they must assess placements with sometimes little to no information. NCFAST is a state case management system that would maintain local agency documentation, case decisions risk and safety assessments that would be accessible to all 100 counties without delay. This would enhance services to families and allow a more thorough risk and safety assessments.

D. Mental Health Services for Families

In eight counties mental health reform and the subsequent confusion of where to seek services and the lack of service providers has been a barrier. This theme is an ongoing theme from the previous fiscal year as this barrier has multiple implications. Often families have to travel out of county to seek mental health and substance abuse services. These services are limited and may not be offered as conveniently as before. Findings from reviews cite lack of services and a confusing system for our families to follow and understand. When mental health services are provided, treatment team meetings are required to ensure families and children needs are being addressed. Meetings should occur monthly with all involved parties coming together to discuss the treatment plan, risk factors and ongoing needs. When children are in the custody of DSS, there should be ongoing communication between the therapist and the social worker with notification to the social worker should the client miss appointments.

Over the past fiscal year, multiple fatality reviews have been conducted in cases involving teen suicide. Many of these cases were known to the mental health system with some of these children having one or more inpatient hospitalizations. Overwhelmingly noted was the lack of follow up with therapeutic services upon discharge from a hospitalization. It is critical for teens to receive ongoing services upon discharge and it is the responsibility of all involved to ensure wrap around services are available and offered. The local DSS are often involved with these families however may have a limited knowledge of the availability of services. The Local Management Entity (LME) could offer training or instructional material to assist DSS with making appropriate referrals.

E. Medical Services for Families

Medical services continue to be a major theme from the last fiscal year involving ten counties and eleven fatality reviews. Medical providers are important to the assessment of any medical concerns related to children and hence should be consulted whenever medical issues are in question. Social workers should not assess these issues in isolation and should utilize tools that are in place to assist with the assessments concerning medical questions. Funding for Child Medical Evaluations (CME) and Child Mental Health Evaluations (CMHE) should continue to ensure that the most serious cases of child abuse and/or neglect are thoroughly assessed. Ongoing recruitment of medical professionals who are willing to provide these assessments is crucial. All medical concerns should be, at a minimum, discussed with a qualified professional capable of rendering a medical opinion on the injury or condition. Medical professionals should have a heightened sense of potential child abuse and neglect risk factors and should refer to pediatric specialist when in doubt.

Additionally, community resources should be utilized for high risk infants at discharge from hospitals. Parents should have a clear understanding of their infant's risk factors with the ability to verbalize and demonstrate in special care needs. Child Service Coordination referrals should be made when risk factors are present that would warrant a referral. Child Development Services Infant/Toddler Service Coordinators (CDSA) should have medical backgrounds that would allow them to assess medically fragile or complex children as well as developmental related disabilities. Often times, high risk infants are involved in multiple services which can make the coordination of these services difficult to manage. Case managers would be an option to assist the primary physical in the coordination of services to this family. Coordination would include scheduling appointments, transportation and verification that appointments were kept. These issues can greatly affect the quality of life for medically fragile infants and may even extend their lives substantially.

As part of the intensive child fatality review, all medical records are requested for all members of the family. These records have not always been provided which impairs the review process. Counties should ensure that medical records have been requested and collected on all family members and/or significant parties to the family to ensure that a thorough child fatality intensive review is completed.

Another issue is the lack of mothers seeking prenatal care. Mothers that seek prenatal care are more likely to have healthy newborns and can have a better understanding of the mental and physical demands that children place on parents. Early education on potential birth defects or complications from substance use or tobacco use is vital to ensuring our future children are healthy.

F. Compliance with the Reporting Law

All citizens are responsible for reporting child abuse. North Carolina G.S. 7B-301 states:

Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, … or has died as a result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found.

This year the State Child Fatality Review Teams often found that reports of suspected abuse or neglect were not made to the local DSS with tragic consequences, as in previous years. Many reviews revealed law enforcement patrol, first responders responded several times to a home of domestic violence and substance abuse prior to the unfortunate death of a child who lived in the home. In addition, many professionals did not make reports when presented with information that warranted a report of suspected abuse and/or neglect. Recommendations from the fatality review teams included the need for more training in the local communities about the requirements for reporting suspected child abuse and neglect, as well as increased public awareness campaigns on how to report such suspicions. Mental health agencies, domestic violence shelters, all hospital and emergency room staff, pediatricians, county employees, educational personnel, emergency management staff, and law enforcement agencies need to be particularly targeted for training on recognizing signs of abuse and neglect and on the requirement for reporting suspicions to DSS. One recommendation was that there should be statewide training on the aspects of reporting child abuse and neglect for professionals outside of the DSS system and for county staff in other program areas, such as Environmental Health. Another recommendation was that the Department of Health and Human Services should require all state and local agencies under the auspices of the Department incorporate in their orientation and staff training programs the aspects of reporting.

Additional clarification is needed with all first responders to child fatalities (EMS, local law enforcement, hospital emergency room staff, medical examiners) about the need to make a report to DSS when a child dies and there are surviving children in the home.

It should be noted that Children's Services Program Management Standards issued by the Division requires that all local DSS's provide regular community awareness and public education programs on recognizing and reporting abuse, neglect, and dependency. Although all of the counties provide regular ongoing community awareness and public education programs, these efforts continue to be needed.

In addition to local efforts, Prevent Child Abuse North Carolina has long played a vital role in raising public awareness statewide about recognizing abuse and neglect and how to report suspicions to the local DSS. This organization has thirty (30) affiliates statewide and has the goal of identifying a member or an affiliate in each community in the state. Through their Helpline (1-800-CHILDREN), they provide information and guidance to citizens on how to report suspected abuse or neglect to DSS. They also provide a Prevention Resource Center that has public education and awareness material and training curricula that is available to local CCPT's and CFPT's. Their web site is also easily accessible at www.preventchildabusenc.org. The organization is in the process of providing training across the state for local community educators, after-school personnel, and child care employees and anticipates around 1,000 individuals being trained. This training is designed for the trainees to have the capacity to return to their local communities to train others in the community on recognizing abuse and neglect and how to report.

In addition to finding that suspicions of abuse or neglect were not always reported to DSS by the community, the review teams identified related issues that involved the DSS intake process. There were several instances where someone from the community believed that they had enough information to report to DSS. Persons making a child protective services report to DSS are often emotional when reporting the information that they have. Information is best received and analyzed by the intake worker if the information is as factual as possible. One recommendation was that intake workers need to ask clarifying questions when using the Structured Intake Tool to assist callers in giving specific, factual information and in defining clearly what they mean. Clear and complete information from the reporter must be documented on the intake form including all allegations of abuse and neglect that need to be addressed by the investigative worker.

V. Conclusion

The contributions of informed state and community professionals that served on the State Child Fatality Review Teams during SFY 05-06 have made this report possible. These individuals devoted countless hours during the reviews, frequently volunteering their time without compensation. The review team members intensively reviewed the circumstances of each child's death and confirmed that protecting children is a shared community responsibility.

The findings and recommendations of these multidisciplinary teams have statewide implications. It is recommended that state agencies and all local communities in North Carolina use this report to examine the issues relevant to the protection of children and the prevention systems in place in order to make any improvements that are indicated. If the lessons learned as a result of a child's death can be applied in such a way as to prevent future fatalities, the state's protection of children will be significantly enhanced and the legislative intent will be met.

Appendix A

Appendix A reflects additional recommendations that were either identified less frequently than those in the body of the report or that were case specific. These are important recommendations that can be implemented statewide.

Division of Social Services

- DSS should offer training to licensed foster parents regarding specific teen issues that may arise when teens are in the foster care system. Topics should include substance abuse, suicide, sex education, and risky behaviors.
- The Cross County Policy should continue to be evaluated. This policy should be consistent with all other policies addressing cross county issues.

Interagency Collaboration and Information Sharing

- Collaboration between agencies is critical for ensuring that families receive holistic assessments. Agencies can not provide services to families in isolation and should be coming together, with the family, to create a plan to ensure access to needed services.
- The State Fatality Review Team needs the entire community record in order to complete an effective review. Substance abuse and school records are often difficult to obtain due to federal laws limiting access. Without these records, it is often difficult to assess the true safety of children and to look at ways to prevent future fatalities.

Medical Examiner Issues

- Autopsy reports should be preformed on a child when that child presents as unresponsive or not breathing and later dies unexpectedly or when there are concerns voiced about the circumstances surrounding the death.
- North Carolina needs a Medical Examiner system that disseminates, distributes and applies the science and other information that exits in the central State Medical Examiner's office through every community and county requiring that information.
- The Medical Examiner's office should complete a thorough death investigation assessment which should include communicating with law enforcement and the emergency management system.
- A trained representative from the Medical Examiner's office should be present at every scene involving a child death.
- Autopsy reports and toxicology screens should be completed in a more timely fashion. Often it takes 6-8 months to receive the final report, this delay may allow for vital crime scene information to be lost.

Community Child Protection Teams

- Membership for the CCPT teams is set forth in statute; however some counties have difficulty getting the required members to attend the meetings. This limited attendance reduces interagency communication and collaboration to protect children.
- Local teams should be identifying risk factors in their counties that impact children's safety and then began to assess funding and services to address those identified needs.

- Local teams should have a clear understanding regarding what cases should be reviewed by the team and clearly define what are the responsibilities of the team members.

Parenting Education/Community Awareness

- Every year, children die due to gun related incidents, therefore continued public awareness regarding gun safety and safe storage of fire arms should be provided.
- Education on safe sleeping practices should be ongoing. All human services providers should be addressing safe sleeping practices during each contact with families and should assess sleeping arrangements are developmentally appropriate.
- DSS should strengthen existing training involving substance abuse to include non-traditionally substances used by teens to achieve a state of euphoria.

School Issues

- Public schools should be more proactive when it comes to attendance. In addition to attendance being important for school achievement, it is also an indicator relating to the child's health and wellbeing. The local CCPT's should hold discussions with their school systems regarding more aggressive enforcement of existing policies including any legal recourse and to better educate the community about the truancy hotline and school options for ensuring school attendance.
- Schools should utilize community resources when concerns do not rise to the level of abuse, neglect or dependency. School social workers should be well versed on these community resources to provide assistance to teachers in making appropriate referrals.
- Schools usually experience misbehavior/behavior disorders on an early basis and need to ensure that these behaviors are appropriately assessed to identify and evaluate potential treatment.
- Schools should follow procedures set forth in N.C.G.S. 115C-378 regarding the accumulation of 10 unexcused absences in a school year.
- Educational records are vital to the completion of a State Fatality Intensive Review. These records should be collected and disseminated to the team members.
- The North Carolina Office of Non-Public Information should establish guidelines on home schooling to include registration, oversight and monitoring of home schools. Funding should be provided to allow for such monitoring.
- All schools should be required to participate in fire safety education to the students.
- Public school systems should aggressively pursue school truancy in teenagers utilizing the court system when necessary.

Miscellaneous

- The North Carolina Department of Transportation should clearly mark all roads when they are approaching a dead end with clear, reflective signs. Signs should also indicate if the road is ending at a body of water.
- It is important for parents/caretakers to submit a missing person report as soon as possible to increase the likelihood of finding missing children.

State Child Fatality Task Force

- There should be continued advocating for nationwide access to criminal records when there is an open children protective services assessment.
- There should be advocating to strengthen the misdemeanor child neglect charges, convictions and sentencing guidelines.
- There should be advocating to change law requiring all child fatalities to be reported to the Division of Social Services.
- Safe sleeping campaign should be initiated across the state.

Appendix B

Appendix B reflects some of the achievements reported by local communities that resulted from recommendations from State Child Fatality Reviews.

- Stop Child Abuse Now (SCAN) created a Memorial wall to honor children that died as a result of child abuse. The Memorial wall is located in Oakwood Cemetery in Statesville.
- Asheville hosted "A System in Crisis" symposium involving 17 mountain counties to gather to discuss and find solutions to the challenges facing the mental health system in the wake of state-mandated reform.
- North Carolina General Assembly approved a tough anti-meth bill in July 2005 which limits the sale of cold medicines with ingredients used to make the illegal drug methamphetamine. This bill requires these medicines be kept behind the counter and includes video surveillance of sales areas for cold medicines containing ephedrine or pseudoephedrine.
- North Carolina General Assembly approved a cell phone ban for teenage drivers in June 2006.
- Chris Leith Chevrolet car dealership teamed up with Wake Forest police, Mothers Against Drunk Driving, Students Against Destructive Decisions and Wakefield High School to put on a safe-driving fair for teenagers in April 2007. The safe-driving fair allowed participants to visit exhibitors including air bag deployments and videos and equipment that simulate being under the influence of alcohol.
- The American Academy of Pediatrics released recommendations in October 2005 addressing safe sleep habits as a result of infants dying due to co-sleeping.
- AmeriCorps assigned two volunteers to Cumberland County in November 2005 to assist with organizing seminars and activities aimed at reducing child abuse, the loss of a job and/or other problems that prompt welfare intervention.
- Carrboro's grocery stores participated in a Sudden Infant Death Syndrome (SIDS) campaign by placing baby food upside down to encourage parents to put child to sleep on their backs.
- Jacksonville held a fire prevention parade in October 2005 to help public awareness about fire safety.
- Friends of First Responders in Jacksonville provides domestic violence awareness. They also provide huggable stuffed dogs that will be in every law enforcement and emergency official car that will be provided to a frightened child during a stressful event.
- To help kick off Red Ribbon Week in Jacksonville, Angels' Voices Speak Up teamed up with Southwest and Jacksonville high school students to produce a variety show that brings awareness to stop family violence and child abuse.
- A government-funded treatment program began in Buncombe County in July 2006. This program is specifically designed to treat methamphetamine addiction based on the Matrix model out of California.
- Governor Easley signed an ATV bill into law in December 2005. This law creates minimum ages allowed to operate an ATV, ATV size restrictions based on age, helmets and face protection requirements and requires a safety certificate to operate an ATV.
- Governor Easley signed a domestic violence bill into law in August 2005 that allows victims of domestic violence to seek emergency concealed gun permits.

- The Healing Place in Raleigh expanded its services in December 2005 to treat homeless drug addicts and alcoholic women and their children in a live-in treatment program. The building under construction is expected to house 88 women and up to 11 of their children.
- Voces Latinas, a nonprofit resource center in New Hanover County provides one of the only prenatal class in Spanish in the area
- A new child advocacy center opened in Gaston County to provide a single location where various agencies can interview abused children and doctors can perform medical procedures as needed.
- The Division has included in state policy the requirement that criminal record checks be completed on all adults living in the home when a child protective services report has been accepted on a family.